INSYST UPDATE V08013 -- RELEASE NOTES 2/7/2008

This release contains bug fixes, new modules, and enhancements to existing functionality. Beginning with release 8.8, we do not attach User Manual documents because of their size. There are three ways to receive updated document segments:

1. If your mailbox can receive large size documents (2MB or higher per document), you can request them directly via email through Insyst Support
2. We will make the documents available via our FTP site**. Please contact Echo Oakland office for the account and password for your county.**
3. You can request the document be sent to you in CD format through Insyst Support.
4. The User's manual, the Reports manual and the CSI chapter from the Operations manual are on the FTP website.

Significant changes and new modules in this release are:

1. Medi-Cal 837 Gross Claim – Prior to this release, Insyst sent net claim amount to Medi-Cal after other payors' payments and/or denials. Effective this release, the Gross Claim amount (your "cost of service") will be used. The new 837 will also include the claim and payment information of other payors. RUN TEST AND UPLOAD TO SEE IF YOUR CLAIM PASSES THE NEW EDITS.
2. New information needed on insurance policies – insured birth date. Staff who enter insurance policies should be notified that the Insurance policy screen will start requiring the birth date of the Insured person. Also all active medi-cal clients who also have an insurance or medicare policy will need to have their policies updated with the insured's birth date information – this is for the new Medi-Cal Gross Claim.
3. Added "Duplicate Override code" to Service Entry screens and MHS Medi-Cal claim process. Please discuss with data entry staff how to answer duplicate prompts when they appear—in other words, when is a duplicate okay and when is it not okay. Even though the state has relaxed the duplicate edit, we have modified InSyst to collect and store duplicate information and send the appropriate duplicate override code on the Medi-cal claim for MHS.
4. Auto NPI – We modified some screens to auto-assign the attending physician to mode 05 and 10 direct service records that otherwise would have been written into the database with a staff 0(zero) prior to this release.
5. Mode 15 services can now be billed to Medi-Cal even if rendering staff does not have a staff NPI. This is done through a new field in the Provider Balance screen—see page 5 of the release notes for the details.
6. CalOMS – Completed the "Delete Admission" transaction processing.
7. CSI – Enhance "Re-Process" step so that prior month services that have never been reported to CSI will be processed as well.
8. Added 4 new reports to show Client's Periodic Data being due or late—see reports manual for details
9. Remove the default NPI of 1111111112 from staff 0 in the staff_master table right after installing this release using datatrieve, so you can take advantage of the

"auto NPI". If there are services stuck in posting with a 0 staff and you need help getting them to post, contact Customer Support for help.. Also you can remove the "default NPI" from the other staff records as well. Populate the field "bill_without_npi" in provider balances before removing the default NPIs and watch posting carefully.

Critical tasks BEFORE/AFTER applying this release:

Before installing this release, you must have successfully applied release 8.12 prior to installing this release.

After installation, you must obtain the new DAS version of Medi-Cal 837 DataJunction map associating with 8.13 and install it before processing the next claim.

Detail of changes:

SCREENS

MHS Service Entry Screens' changes for Medi-Cal Duplicate Override:
The current service entry screens detects "duplicate" so that it does not break the unique index. If a duplicate is confirmed by user, the screen adds 1/100 of a second to the service date field to avoid duplicate index being created in the database. The duplicate edit rule has been expanded so that

a) If the service breaks the unique index, the screen should automatically increment the service date by 1/100 second **without** prompting user about "duplicate ok" question, with the following exceptions: Ancillary, Component, Daily, Weekly, and Dosing. Historically, services entered through these screens should not have been provided by the same staff on the same day for the same RU, same client, and same procedure. Therefore, if the primary therapist is not the same, user is able to acknowledge the "duplicate ok" prompt. However, if everything is the same including the staff, these screens will abort and the duplicate service can not be entered.
b) Redefine the elements of duplicate according to CA Medi-Cal claiming rule, when another existing service having the same value of the following fields, then prompt user to confirm that this is a valid duplicate entry. The fields used for the new check duplicate algorithm are: Client Number, Reporting Unit, Service Date, Procedure code, hours, and minutes. If there is another service with same values in these fields, prompt user to okay the duplicate. If user enters "N" (No), do not store the service record. If user enters "Y" (Yes), store the record and specifying that this is a duplicate service (see steps 2-5 on page 6 of the release notes under "when posting detects a duplicate" to see what posting will do)

c) Add a new field DUPLICATE_SERVICE_MASK (data type longword) to DIRECT_SERVICE.
d) Write value "1" if user okays the duplicate at time of service entry.
e) Screen changes apply to both MHS and DAS where appropriate.
f) Duplicate override have been implemented in the following screen:
g) Changes to existing service entry screen:
    i) **Ancillary Service Entry** – Add new check duplicate algorithm. Abort if duplicate found. (Note: Duplicate means two services having same client, service date, RU, procedure code, hours, and minutes.)
    ii) **Dosing** – Add new check duplicate algorithm. Abort if duplicate found.
    iii) **Appointment Service Entry** – Add new check duplicate algorithm. Prompt user to okay if duplicate found. If user enters "N", do not store the service. If user enters "Y", store service with a 1 in the duplicate_service_mask.
    iv) **Multi Service Entry** – Add new check duplicate algorithm. Prompt user to okay if duplicate found. If user enters "N", do not store the service. If user enters "Y", store service with a 1 in duplicate_service_mask field.
    v) **Single Service Entry** – Add new check duplicate algorithm. Prompt user to okay if duplicate found. If user enters "N", do not store the service. If user enters "Y", store service with a 1 in duplicate_service_mask field.
    vi) **Urine Test Service Entry** - Add new check duplicate algorithm. Prompt user to okay if duplicate found. If user enters "N", do not store the service. If user enters "Y", store the service with a 1 in duplicate_service_mask field.
    vii) **Service Maintenance** – Add new check duplicate algorithm. Prompt user to okay if duplicate found. If user enters "N", do not store the service. If user enters "Y", store service with a 1 in duplicate_service_mask. Also the field DUPLICATE_SERVICE_MASK will be available for update when user invokes the "supervisor mode". User can enter either Y or N and the screen converts it to 1 or 0 when storing it to the database.
    viii) One-shot Episode service – Can't enter duplicates on this screen..

MHS Screen changes on NPI requirements: For current **service entry** screens (Ancillary, Daily, Weekly) that default staff number to 0 (zero), the change is to default staff number using the algorithm below.

a) Check the Mode of Service in Provider Balances table. If the **mode is "05" or "10"** (Inpatient or Day Treatment), look up EPISODES.PHYSICIAN field. Check if this staff

has a NPI. If so, use this staff number as the primary therapist. If no NPI, then continue to the next step.

b) Look up PROVIDER_MASTER.PROGRAM_PHYSICIAN field and see if this staff has an NPI. If so, use this staff number as the primary therapist. If not, then default the primary therapist to 0 (zero).

Insurance Policy entry/maintenance screen: Add a new field for INSURED_BIRTH_DATE. Users should begin to populate this field for new entry and update this value for existing records. The insured birth date is a value needed for Medi-Cal 837 "Gross" claim creation.

MHS Client Registration/Maintenance screen: Add a new field called "CSI Anniversary Date". This new field works with the four new reports PSP 371-374. If this field is blank, then calculation of Periodic Due Date will be based on the most recent entry of Periodic record. However, if a valid date value is entered into this field, then this is the anniversary date when the CSI Periodic Review is due.

DAS Episode Closing screen: Previously the screen did not validate the Discharge Status if the value was zero. This has been fixed and all value being put into this field will be validated.

DAS Episode Maintenance screen: Users were forced to update some closing values such as Homeless before s/he could re-open the episode. This screen's behavior has been changed so that user can go straight forward to re-open the episode.

DATABASE Changes

Table: PROVIDER_BALANCES
Add column BILL_WITHOUT_NPI PIC X (1);

Table DIRECT_SERVICES
Add column DUPLICATE_SERVICE_MASK Longword;

Table CLAIM_LINES
Add column MCAL_ID PIC X (24)
Add column MCAL_ID_PREVIOUS PIC X (24)
Add column BILL_WITHOUT_NPI PIC X (24)

Table SPECIAL_POPULATION_MASTER

Add column SPECIAL_POPULATION_LABEL PIC X (20)

Table CLIENTS
Add Column CSI_ANNIVERSARY_DATE DATE

POSTING AND OTHER BMENU

Medi-Cal Claim 837I/P change: Effective this release, MHS Medi-Cal 837 will be in the "Gross Claim" format. In the past, Insyst submit the "Net Claim" amount to DMH, which is the "Cost of Service" minus payments or approved amount from other payor sources. When switching to "Gross Claim" format, Insyst will send the "Cost of Service" and other payors' claim and payment information. DMH will calculate the claim amount based on these data.

***** IMPORTANT NOTE:** Since this version of Medi-Cal will be sending MORE information from other payors' activities to DMH, County staff is advised to rigorously test the new version before using it for production claim. During Echo's beta testing at County's pseudo production environment, we discovered missing data that are required for the submission (For example: Insured Name in Insyst's Insurance Policy record. The record must have both First name and Last Name. Some users use this field creatively by entering "Do Not Bill" in this field.). We also saw duplicate insurance payments being entered, thus reducing the "net" claim to Medi-Cal. There are also situations where the claim procedure code (i.e. 916) was accepted and paid by 3-rd party insurance but this code failed Claredi's edit. (Error message: "The procedure code "916" is not a valid CPT or HCPCS code for this date of service.)

Therefore, you should get a clean 997 from a "monthly" test submission before considering switching to production.

BMENU changes for **MHS**:
For outpatient services, we will add a new field called BILL_WITHOUT_NPI in the Provider Balances table. The valid values are Y or N. County may allow services under any mode "15" Provider Balances to bill to Medi-Cal even if rendering staff's NPI is not available. To do so, update the PB record via Provider Balances Maintenance screen with "Y" in this field.

The monthly Provider Balances Transfer program, available in BMENU, will also be updated to transfer the value in this new field.

Posting changes for **MHS** related to NPI:
The service posting will be updated so that if the rendering staff does not have an NPI, and if the mode of service is "15", posting will check the value in BILL_WITHOUT_NPI in the Provider Balances table. If "Y", it will then write a Medi-Cal claim record for this service. We will also add the new field BILL_WITHOUT_NPI to the CLAIM_LINES table. And this field will receive a value of "Y" when the above condition is met.

For mode 05 and 10 services that do not have a default physician with valid NPI in Episode or Provider Master, the 0 staff used will fail posting and get an error message in SEQ_LIS.

Posting changes for **MHS** related to Duplicate Override:

The edit of duplicate needs to be perform again during service posting. At time of posting the module obtains the values of Client number, CDS Provider Code, Service Date, Mode, SFC, Units of Time, Units of Service, and net claim amount, which is the data set used in State defined Medi-Cal "Duplicate".

When posting detects duplicate, the following steps are taken:

1. Locate all services for the same client number and same service date (Note: There can be multiple duplicates with each having increments of 1/100 second(s). All will be examined.) These other services being compared with the service being posted should have Actual FRC bit 2 "ON", meaning that they are/were billed to Medi-Cal.
2. Compare 4-digit CDS Provider Code, hours, minutes. If all equal, continue to next step. Otherwise, this is not a duplicate and posting continues.
3. Use Program code(MHS is 01, DAS is 20 or 25), Medi-Cal mode of service from Provider Master, and SFC from provider balance, to look up a record in CA_MEDICAL_CROSSWALK for the services. Retrieve the BILLING_CODE (this is the HCPC code used to bill Medi-Cal) from the record. If this code is equal then continue to next step. Otherwise, this is not a duplicate and posting continues.
4. Now that we have found two services with same client, service date, CDS provider, units of time, mode, and SFC. The only thing left to check is the net billed amount. Compare the Medi-Cal claim amount. If they are the same, then we have a "duplicate service" according to Medi-Cal. Otherwise, this is not a duplicate and posting continues.
5. Compare the duplicate check result and the value in DUPLICATE_SERVICE_MASK (1=YES, 0 = NO) and take **one** of the following four actions:
    a. Found duplicate in posting and duplicate mask in direct service is 1 (Yes): Store "Y" in CLAIM_LINES.MODIFIER_2 field. This will trigger Insyst MediCal claim process to send the Duplicate Override code.
    b. Found duplicate and Mask is 0 (No Duplicate Override): Skip this service from posting to Medi-Cal. Print error message in SEQ_LIS to show that duplicate service not authorized by user for Medi-Cal billing.
    c. No duplicate found during posting and mask is 1 (Yes): Suppress the duplicate override action. Claim Medi-Cal as normal.
    d. No duplicate found during posting and mask is 0 (No): This is normal Medi-Cal billing. Continue as usual.

Medi-Cal Intermediate file and DataJunction map changes for **MHS**:
Update MHS Print Medi-Cal Claim process to pass BILL_WITHOUT_NPI value to the intermediate file. Update DataJunction map so that Loop 2420A will be dropped if "Y" to bill Medi-Cal without NPI.

Medi-Cal Intermediate file and DataJunction map for **DAS**:
Update DAS Print Medi-Cal Claim process to pass the BILL_WITHOUT_NPI value to the intermediate file. Update the DataJunction map so that Loop 2420A will be dropped if "Y" to bill Medi-Cal without NPI.

How to determine which Taxonomy code to use in a Medi-Cal claim:
For FFS services uploaded from eCura, the taxonomy code can be different depending on whether the same provider was providing an individual service or a group service. The posting and Medi-Cal claim module will be enhanced with the following algorithm to determine which taxonomy is to be used for claiming:

1. Check FFS_NOTE in the Provider Master table. If blank, then this is a normal non-FFS Medi-Cal claim. Use taxonomy from the Medi-Cal Crosswalk table. Otherwise continue to the next step.
2. Compare the rendering staff's NPI with the Facility NPI in the Provider Master record.
    a. If equal, then this is a FFS individual service. Use the staff record's taxonomy for 837 claim.
    b. If not equal, then this is a group practice service. Use the standard "Group practice" taxonomy code (193200000X) for 837. Look up this taxonomy code in INSYST_OPTIONS table. (see below)

The "Group practice" taxonomy specified in the Medi-Cal 837 Companion Guild will be stored in the INSYST_OPTIONS table. The 8.13 release will automatically insert this record. Use OPTION_NAME to look up the record. The actual taxonomy code is stored in OPTION_STRING_VALUE.

OPTION_NAME = "FFS GROUP TAXONOMY"
OPTION_VALUE = ""
OPTION_STRING_VALUE = "193200000X"

Note: All changes mentioned above do not apply to Medicare or Insurance posting and claiming processes. If a service is billable to Medicare or Insurance, and the rendering staff's NPI is missing, the service will NOT be posted to either payor and will remain in 1-12 billing status.

Posting Changes for **DAS**
When a service is being posted to Medi-Cal, the posting module will read the MEDICAL_PROGRAM_CODE from the provider master table, the MEDICAL_MODE_OF_SERVICE from the provider master table, and the

SERVICE_FUNCTION_CODE from the provider balances table. Use these 3 fields to look up a record in the CA_MEDICAL_CROSSWALK table by matching the PROGRAM_CODE, MEDICAL_MODE, and MEDICAL_SFC. Retrieve the value in BILLING_CODE in the crosswalk table.

If the billing code retrieved is either H0004 or H0005, then the rendering staff's NPI is required. Skip the service and print an error message in SEQ_LIS if the required NPI is not in the staff master record for the primary therapist.

If the billing code is neither H0004 nor H0005, then the value "Y" is stored in CLAIM_LINES.BILL_WITHOUT_NPI.

Insurance Policies Posting enhancement:
One major enhancement was added to Insurance posting module related to late Insurance or late Medicare policy entry.

After Medi-Cal eligibility was established and service was provided, Insyst service posting module creates pending Medi-Cal claim. This claim remains pending in the system until the next claim printing cycle. Meanwhile, if a Medicare policy is entered and activated in Insyst, service posting will create Medicare claim with the FULL cost of service amount. In such case, the Medi-Cal claim is not being billed with the remaining balance after Medicare payment, nor does it have the proper 'crossover indicator' in the claim record.

To address this problem, the Insurance Policy posting module has been modified to do the following:

1. For each new Medicare or Insurance policy, review all services within the effective/expiration period of the policy.
2. For each service, check to see if there is a "pending" Medi-Cal claim.
3. If yes, unpost the "pending" Medi-Cal claim. This involves deleting the Medi-Cal related records in Receivables, Claim Lines, and possibly Claim Forms (if no more claim line linked to this claim form).
4. It will also reverse the service record so that, when payment or denial comes back from Medicare (or Insurance), the service is ready to be posted again to Medi-Cal.

Minor BMENU bug fixed: While in BMENU, if user hits RETURN key instead of selecting available menu choices, the following error message appears and user is forced back to the $prompt:

%DCL-W-USGOSUB, target of GOSUB not found - check spelling and presence of label

This error is fixed in this release.

Minor BMENU label Change: Claim selection of UB92 is now called UB04.

CMS1500 Claim change: The claim unit has been “010” for one unit, which we believe was correctly processed by the payor. The new print unit will be “1” without leading or trailing zero.

REPORTS

New reports:

Report PSP371 – Periodic Review Due Report, distributed by Client’s Primary Reporting Unit.

Report PSP372 – Periodic Review Due Report, distributed by Episode’s Reporting Unit.

Report PSP373 – Periodic Review Overdue Report, distributed by Client’s Primary Reporting Unit.

Report PSP374 – Periodic Review Overdue Report, distributed by Episode’s Reporting Unit.

Reports enhanced:

Report PSP 366 – This new version only reports “active” clients that qualified for Healthy Family “exact match” criteria.

Report PSP 367 – This new version only reports “active” clients that qualified for Healthy Family “partial match” criteria.

(See more detail on these reports in Insyst Report Manual, available for download via our FTP side.)

Enhancement to existing reports:

Report PSP493 – Remove unwanted V71.09 or 799.9 from Supplemental Axis I, II, and III. Also, set Axis 5 to "000" if blank or zeros or unknown. These changes should help eliminate some CSI errors from the FFS services uploaded to Insyst.

STATE REPORTS

CalOMS Generate – We further enhanced the "Delete Admission" transaction process. Per County's discussion with ADP, before a "Delete Admission" can be sent, we must first send the "Delete Discharge" transaction if the episode was closed. Then, "Delete Annual Update" transaction for each distinct "Annual Update" transaction sent in the past. And, finally, the "Delete Admission" transaction itself. This latest version of CalOMS will automatically generate the above transactions, where appropriate, for the "delete episode" action in Insyst.

CalOMS Extract – A sort algorithm is implemented to show the transactions related to "Delete Admission" as described above. No change to the order of other transaction types.

Documentation

The Insyst Users Manual, version 8.12, on Echo's FTP server had an older version of screen for DAS Episode Closing. In that the screen shot missed the recently added field "Client Homeless at Discharge" on the first page of the closing screen. This has been corrected and the Users Manual was updated on Dec 21st.